



# Bridging the gap: The impact of home visiting programs for orphans and vulnerable children on social grant uptake in South Africa



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## ABSTRACT

Cash transfer programs hold significant potential to mitigate the economic burdens resulting from the HIV epidemic and enhance the wellbeing of affected children. South Africa offers two cash transfers designed specifically to benefit children: the Child Support Grant, for low income families with children, and the Foster Child Grant, for children living outside of parental care. Given the high proportion of HIV-affected children who qualify for these grants, increasing grant access among eligible families is a natural objective for many programs targeting orphans and vulnerable children. We present results from a quasi-experimental study examining differences in grant uptake over a two year period among 1487 children enrolled in one of two types of supportive home visiting programming: volunteer-based or paraprofessional. The study also examined related outcomes including household food security and children's access to basic educational and material needs. Results show that programs staffed with trained paraprofessionals who received training, compensation and other support were significantly more effective at linking families to social grants for children. Controlling for important covariates, at follow-up participants in the paraprofessional model programs were nearly three times as likely as volunteer-based service recipients to have access to the highest grant they were eligible to receive. Grant receipt was also positively associated with household food security and children's attainment of basic educational and material resources. Effective strategies for promoting social grant access among HIV-affected households therefore have the potential to yield significant improvements in wellbeing for orphans and vulnerable children.

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## 1. Introduction

The HIV epidemic in sub-Saharan Africa exhibits profound effects on communities' economic stability. In addition to reducing human capital, HIV increases resource demands on affected families, many of whom are already poor. Chronically ill adults experience diminished capacity to work and provide care, while children in affected households—regardless of their HIV status—may be more likely to drop out of school to care for younger siblings or sick parents, or to seek employment themselves (United Nations Children's Fund, 2011). When children's caregivers die these social and economic stresses are magnified, and households that take in orphans assume new financial and caregiving burdens.

The elevated economic burdens imposed by HIV are particularly salient in South Africa, home to world's largest HIV epidemic (UNAIDS, 2013). In 2012 an estimated 61% of South Africans under age 18, more than 11 million children, were living in poverty (Berry, Biersteker,

Dawes, Lake, & Smith, 2013). UNICEF reports that while 19% of the country's children have lost one or both parents, this estimate is 24% among children in the poorest income quintile compared to only 5% in the richest, suggesting that orphanhood and poverty are strongly linked (South African Human Rights Commission/UNICEF, 2011). According to some estimates, the HIV epidemic in South Africa could increase the prevalence of chronic poverty there by as much as 33% overall (Aliber, 2003). These severe economic challenges limit families' abilities to meet children's basic needs and may beget a vicious cycle of poverty and disease.

Cash transfer programs are one promising strategy for mitigating the financial hardships facing HIV-affected households in sub-Saharan Africa (Adato & Bassett, 2009; Richter, 2010). Literature reviews illustrate the beneficial effects of cash transfer programs on children's health, nutrition, education, and HIV prevention outcomes (Barrientos, Byrne, Peña, & Villa, 2014; Lagarde, Haines, & Palmer, 2007; Pettifor, MacPhail, Nguyen, & Rosenberg, 2012; Robertson et al., 2013; Vincent & Cull, 2009). Recognizing the proven utility of cash transfers, in 2006 thirteen African countries including South Africa signed the Livingstone Call for Action in support of the expanded adoption of social cash transfer programs (Intergovernmental Regional Conference, 2006).

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South Africa already offers one of the largest cash transfer initiatives on the continent, with two grant types oriented specifically to children. The child support grant (CSG), a means-tested cash transfer targeted to low-income individuals providing primary care for a child under age 18, was directed to more than 11 million beneficiaries in 2013. Fewer recipients, about 500,000 in 2013, were receiving a foster child grant (FCG), which is available to the court-appointed guardians of children living outside parental care (often as a result of orphanhood, abandonment, abuse or neglect) (Berry et al., 2013). The monetary value of the foster child grant is nearly three times that of the child support grant (310 ZAR/\$30 and 830 ZAR/\$80 respectively in 2014; [www.services.gov.za](http://www.services.gov.za)).

These grants are highly responsive to the economic burdens and caregiving situations resulting from the AIDS epidemic. For instance, an estimated 50% of FCG recipients live in AIDS-affected households (Schubert, 2007). Moreover, promoting access to social grants is a key facet of the government's National Action Plan for support of orphans and vulnerable children (OVC) (South African National AIDS Council, 2012). However, the program's administrative complexity and other significant barriers limit the program's reach.

Receipt of either the child support or foster child grant requires a formal application to the government, including the submission of identity documents and other paperwork. The FCG additionally requires a court appearance, supplemental documentation such as parental death certificates and/or affidavits concerning parental whereabouts, a formal social work assessment, and biennial review. Substantial confusion exists around income thresholds, employment restrictions, nationality requirements, and other evolving eligibility criteria, leading many potential applicants to wrongly assume they are disqualified (DSD, SASSA, & UNICEF, 2012). Lack of identity documents and death certificates, literacy barriers and transport costs to government facilities further discourage eligible families from applying (Twine, Collinson, Polzer, & Kahn, 2007). Finally, considerable backlog in application processing, especially for FCGs, deters many eligible families from timely grant access (Hall & Proudlock, 2011).

While the CSG is targeted explicitly at poor children, nearly one-quarter of eligible children were not receiving it in 2013 (Berry et al., 2013). Access may be even lower among eligible HIV-affected children. A study in KwaZulu-Natal, the province with the highest HIV prevalence (Department of Health, 2011), found that less than 40% of CSG-eligible households that had experienced a recent death and only 30% of those fostering orphans were receiving the grant (Adato & Bassett, 2012). Another study of households suffering HIV and AIDS-related morbidity or mortality similarly found that less than one fifth received a CSG and less than 10% received a FCG (Booyesen & Van Der Berg, 2005). Studies have also shown that orphans, particularly maternal orphans, are less likely than their peers to receive a CSG (Case, Hosegood, & Lund, 2005; Woolard & Leibbrandt, 2010). Finally, research suggests that only a small proportion of eligible children receive the FCG; instead, many receive a CSG or no grant at all (Hall & Proudlock, 2011).

Additional efforts are clearly needed to promote OVC's access to this critical safety net. Home visiting programs are the most common strategy for serving OVC in sub-Saharan Africa, aiming to provide multi-faceted support that includes linkages to social services (Schenk & Michaelis, 2010). Home visitors may be particularly well-positioned to promote access to cash transfers through information provision, support and follow-up with high priority underserved households. They can educate caregivers about programs for which they may qualify, help obtain the necessary documentation, assist with completing applications, and check the status of pending applications. Home visitors in some program contexts can also guide caregivers through the process of obtaining legal recognition of their status as foster parents.

In light of substantial evidence suggesting that cash transfers are an effective, worthwhile investment, identifying best practices for ensuring that all children in need have access to this important resource is a priority. To our knowledge, there has been no study of interventions aimed at increasing access to social cash transfer programs among OVC

generally, or of the role of the home visitor in these processes. The present study examines the capacity of a trained and compensated workforce of home visitors to link the OVC population in South Africa to child-focused cash transfer programs over a two-year period, using a quasi-experimental design. Analyses further explore the apparent effects of cash transfers on household food security and caregivers' ability to meet the basic material and educational needs of this highly vulnerable population.

## 2. Materials and methods

### 2.1. Study design and sample

The findings presented here are drawn from a longitudinal study designed to assess the effectiveness of OVC home visitation programs operating in rural KwaZulu-Natal, South Africa, where antenatal HIV prevalence nears 40% (Department of Health, 2011). Children aged 10–17 years who were newly enrolled in these OVC programs were invited to participate in the study. Information on children and their primary caregivers was collected in two survey rounds: at enrollment into the program in 2010, and at follow-up in 2012, after approximately two years of program engagement. A maximum of two age-eligible children per caregiver were included in the study. Face-to-face interviews were conducted in the local language isiZulu after obtaining informed consent from caregivers and assent from child participants; these visits took place privately at the participants' home. Up to three visits were conducted to locate children, and every effort was made to find and interview children who had moved within KwaZulu-Natal between survey rounds. The study successfully followed 80% of children interviewed at baseline. This investigation is limited to the 1472 children and 918 caregivers with survey data from both rounds. Further details about the panel study can be found elsewhere (Thurman, Kidman, & Taylor, 2014).

### 2.2. Intervention groups

This study capitalizes on the enormous variation in how OVC home visiting programs are structured and implemented in order to generate a quasi-experimental design. On one end of the continuum, small community-based programs operate with no external resources, rely on lay volunteers, and typically attain low levels of basic service delivery coverage. On the other end, well-resourced programs provide extensive accredited training and full-time compensation for their home visitors, and generally deliver a broader array of more intensive services to a higher proportion of enrollees. We thus classified the home visiting programs as utilizing either a paraprofessional model (those that offer training and compensation for the care workers who perform home visits) or a volunteer-driven model (those that rely primarily on lay volunteers). To enhance generalizability, this study included two distinct paraprofessional models operating across 14 sites, and volunteer-driven approaches being uniquely implemented by individual community based organizations within 16 different sites across KwaZulu-Natal.

Using improvement in the volunteer-driven group as a comparison, this study evaluates the impact of enrollment in a paraprofessional home visiting program on children's social grant uptake. Importantly, while randomization was not feasible, the volunteer-driven group closely approximates an untreated control group as only 34% reported ever receiving a home visit, dropping to only 14% who reported being visited in the year prior to the follow-up survey. More information on the OVC programs and services provided can be found in previous publications (Kidman, Nice, Taylor, & Thurman, 2014; Thurman et al., 2014) and in related case-studies (Neudorf, Taylor, & Thurman, 2011; Njaramba, Byenkya, Pillay, Oti, & Ntsala, 2008; Thurman, Yu, & Taylor, 2009).

### 3. Measures

#### 3.1. Primary outcomes

For each child, caregivers were asked about eligibility for and receipt of the CSG and FCG as appropriate. The primary eligibility criteria for each grant were used to generate an approximate measure of eligibility in the study sample (see Table 1). For the CSG, children were classified as eligible if they met the age requirement (<15 years old in 2010 and <18 years old in 2012); their primary caregiver reported being a South African citizen; and the child was not already receiving a FCG. All but three primary caregivers reported that they were a South African citizen. Almost all (98%) of the caregivers reported total household earnings under R2500 per month (about \$250), which is within the range required by the income means test to receive either grant. For the FCG, children were classified as eligible if under age 18 and not living with a biological parent, whether or not a legal foster parent had been appointed.

Eligibility was assessed separately at baseline and for follow-up. Children who were not eligible for a grant at baseline could become eligible in the interim, both because eligibility was eventually extended to age 17 years for the CSG and because some children became newly eligible for the FCG when a parent died. Children lost eligibility between rounds if they reached their 18th birthday, although exceptional cases of grant retention have been made for foster children still in school at the age of 18.

#### 3.2. Child wellbeing

Across Southern Africa, research has shown that cash grant funds are typically expended on food, material goods and education and correspond to improvements in children's wellbeing in these areas (Adato & Bassett, 2009; Devereaux, Marshall, MacAskill, & Pelham, 2005; Miller, Tsoka, & Reichert, 2011; Miller, Tsoka, Reichert, & Hussaini, 2010). The present study looked for evidence of similar effects in this South African program context.

The Household Food Insecurity Access Scale (HFIAS), developed by the Food and Nutrition Technical Assistance project (FANTA) in 2006, was used to characterize households along a 28-point continuum from food secure to severely food insecure (Coates, Swindale, & Bilinsky, 2007). Caregivers were first asked to indicate whether nine situations reflecting major dimensions of food insecurity had been true at any time in the past 30 days. Situations range from not being “able to eat the kinds of food you preferred because of a lack of resources” to going “a whole day without eating anything because there was not enough food.” For each affirmative response, the respondent was asked to report the frequency of the occurrence; responses were used to determine their level of food insecurity. The distribution was heavily skewed; thus we produced a dichotomous variable for use: food secure/mildly insecure and moderately/severely food insecure.

We also focused our study of outcomes on material and educational resources that go directly to the child. Children were asked if they

possessed each of the following: two sets of clothing (excluding school uniforms); a pair of shoes; and a blanket for sleeping. Material needs were classified as met if children had all three of these items and classified as unmet if they lacked any one of the items. While past research has demonstrated significant cash transfer input towards school enrollment dues, public schools fees have since been eliminated in South Africa. Approximately 98% of the sample was already enrolled in school at the time of the study; we thus focused on the kinds of related resources that encourage school attendance and enable children to succeed: a school uniform, notebook, pen or pencil, and textbook. School resource needs were classified as met if children had all four of these items and classified as unmet if they lacked any one of the items.

*Other covariates:* We include additional covariates that are likely associated with intervention exposure, with potential receipt of a grant, and/or with the secondary child wellbeing outcomes. For example, living with a biological parent is correlated with intervention group, and is a demonstrated predictor of both CSG receipt (DSD et al., 2012) and child wellbeing. The full list of covariates includes child characteristics (age, gender, orphan status, and relationship to caregiver); caregiver characteristics (age, gender, marriage status, educational status), and household characteristics (illness, dependency ratio, income level, rural/urban status). The above covariates were measured at both baseline and follow-up for inclusion in analyses. For select child wellbeing models, we additionally included reported receipt of food parcels or school supplies measured only at follow-up.

#### 3.3. Analyses

Means and frequencies are used to illustrate child characteristics, grant access and service provision at baseline; *t*-tests and chi-squared tests are used to evaluate between-group differences. An intention-to-treat analysis was conducted to test for the effect of paraprofessional home visiting on grant uptake (i.e., children were analyzed based on their enrollment in a given program model, regardless of whether they reported receiving program services). We model the impact of paraprofessional home visiting on grant uptake (defined as obtaining the highest grant for which they were eligible) using multi-level mixed effects logistic regression (MLM). We analyze observations over time among individuals who are nested within households. We therefore specify a three-level model with random intercepts that nest observations within individuals and individuals within households. The model is limited to children eligible for a grant and controls for baseline grant access, follow-up grant eligibility (CSG or FCG), and relevant covariates described above measured at both time points. The model included program exposure (dichotomized by enrollment in the volunteer or paraprofessional treatment models), time (baseline or follow-up), the program group by time interaction, and relevant covariates. The time by program group interaction term captures the relative impact of paraprofessional home visiting. A second set of multi-level logistic regression models estimate change in child wellbeing indicators over time as a result of newly acquired grant access. For example, to analyze the relationship between grant receipt

**Table 1**  
Eligibility criteria for the child support and foster child grant in South Africa.

Grant	Year	Who can apply?	Additional eligibility criteria
Child support grant	2010	Primary caregiver of a child under 15 years old	<ul style="list-style-type: none"> <li>•Applicant must be a citizen or permanent resident</li> <li>•Monthly income under 2500 Rand/5000 Rand for single/married caregivers (\$250/\$500)</li> <li>•Applicant may not receive grant for more than 6 non-biological children</li> <li>•Applicant cannot receive grant if they hold a Foster Child Grant for the same child</li> </ul>
	2012	Primary caregiver of a child under 18 years old	<ul style="list-style-type: none"> <li>•Same as above except:</li> <li>•Monthly income under 2800 Rand/5600 Rand for single/married caregivers (\$280/\$560)</li> </ul>
Foster child grant	2010	Foster parent of a child under 18 years old <sup>a</sup>	<ul style="list-style-type: none"> <li>•Applicant must be a citizen, permanent resident or refugee</li> <li>•Must submit court order placing the child under care of the applicant</li> </ul>
	2012	Same as above	<ul style="list-style-type: none"> <li>•Same as above</li> </ul>

<sup>a</sup> Can be extended beyond 18 if the child remains a dependent and is completing formal schooling.

and material resources, we run regressions examining material resources at follow-up in 2012 including indicators that the child received a new grant (CSG or FCG) during the study period, controlling for aforementioned covariates and baseline material resources. We ran similar models for food security and educational resources, also controlling for receipt of food parcels and school supplies respectively. All analyses are conducted in Stata version 12.

## 4. Results

### 4.1. Child characteristics at baseline

Table 2 shows the characteristics of the children in the study at baseline by program model. Important differences in the composition of the groups emerged and are controlled for in subsequent analyses. These differences include a higher prevalence of de facto foster children (i.e., those not living with a biological parent) in the paraprofessional group. This is reflected in a greater reliance on older grandparents and other relatives as children's primary caregivers.

Other covariates were similar across intervention group, but speak to the highly vulnerable nature of this population. Few caregivers were married and a third had no formal education. Chronic illness was present in two-fifths of all households, likely reflecting the high incidence of AIDS-related morbidity in this population. Finally, approximately 80% of households reported earning less than 1000 Rand (\$100) a month in income, excluding grants.

### 4.2. Grant access

The majority of beneficiaries were presumed eligible for either the CSG or FCG at both baseline and follow-up (87% and 79% respectively). Despite widespread eligibility for child grants at baseline, a notable proportion of enrolees had not accessed these resources and many were accessing a lower grant than they were eligible to receive. As highlighted in Table 3, 36% of eligible children were not receiving a grant at baseline. A further 15% were receiving the CSG, but were eligible for a larger monetary award through the FCG. The remaining 49% were receiving the highest grant they were eligible for; whether this was a CSG or FCG depended on the underlying distribution of foster children in the program population.

There was a marked increase in grant access between baseline and follow-up among study participants in both program groups. At follow-up, the percentage of children receiving the highest grant for which they were eligible jumped to 63%, reflecting increases in both CSG and FCG access. Notably, children in the paraprofessional programs were more likely to have received the highest grant they were eligible to receive, as compared to children in the volunteer-driven programs. Paraprofessional program enrolees receiving the highest possible grant rose from 44% to 66% between the study's two data collection rounds. The proportion of grant-eligible children receiving a FCG in particular increased from 36% to 54% among this group, as compared to only a 7% improvement among their counterparts in volunteer-driven programs. Access to the CSG rose more modestly for enrolees of both program models. After controlling for important covariates, participants in the paraprofessional model programs were nearly three times as likely to have access to the highest grant they were eligible to receive (AOR 2.92,  $p$ -value < 0.001). In spite of these achievements, some gaps remain at follow-up across both program model types. About one-fifth of children in the study were receiving the CSG despite being presumably eligible for the larger FCG. A similar number lacked access to any grant, although this drops to 10% when considering the 5% with reported pending applications.

### 4.3. Child wellbeing

Table 4 presents estimates of the average impact of grant uptake during the study period. In regression analyses the receipt of child-level social assistance grants was significantly associated with both greater fulfillment of basic needs ( $p < .001$ ), including material needs (e.g., clothing, shoes, and a blanket) and school resources (e.g., uniform, writing materials). A positive trend ( $p = .08$ ) was apparent with respect to new grants and household food security.

## 5. Discussion

This study found that programs with paraprofessional home visitors significantly improved uptake of social assistance cash transfer programs among HIV-affected households in South Africa. While grant receipt also increased over time for families enrolled in volunteer-driven home visiting programs—likely in part due to outreach and promotion by the Department of Social Development (DSD) and civil society

**Table 2**  
Characteristics of children at baseline by program model.

(All % unless otherwise indicated)	Total sample $n = 1487$	Volunteer-driven $n = 894$	Para-professional $n = 593$	Group difference
<i>Child demographics</i>				
Female	52	51	53	
Mean age in years	13.60	13.59	13.61	
Foster child	65	54	83	***
<i>Caregiver demographics</i>				
Relationship to child				
Parent	29	39	13	***
Grandparent/aunt/uncle	58	59	72	***
Sibling	11	9	13	*
Other	3	3	2	
Female	93	92	95	**
Mean age in years	48.63	46.78	51.34	***
Married	20	21	17	
No education	31	30	34	
<i>Household demographics</i>				
Mean dependency ratio	0.94	0.99	0.86	**
Ill household member	43	44	42	
Monthly non grant income level < 1000 Rand (\$100)	81	82	79	
Rural	87	82	94	***

\* $p < 0.05$ , \*\* $p < 0.01$ , and \*\*\* $p < 0.001$  for test comparing volunteer-driven and paraprofessional home visiting models;  $t$ -tests are used for continuous outcomes and chi-square tests for categorical outcomes.



**Table 3**

Access to social grants by round and program model.

	Baseline (%)			Follow-up (%)		
	Total sample	Volunteer-driven	Para-professional	Total sample	Volunteer-driven	Para-professional
<i>Grant receipt</i>						
None	36	34	39	17	17	17
Lower grant: CSG	15	14	17	20	23	17
Highest possible: CSG	20	28	8	23	31	12
Highest possible: FCG	29	23	36	40	30	54

+ Multi-level mixed effects logistic regression model found that paraprofessional enrollees were significantly more likely to have access to the highest grant they were eligible to receive (AOR 2.92,  $p$ -value < 0.001) after controlling for child characteristics (age, gender, orphan status, and relationship to caregiver); caregiver characteristics (age, gender, marriage status, educational status), and household characteristics (illness, dependency ratio, income level, rural/urban status).

organizations—beneficiaries served by paraprofessional home visitors were nearly three times as likely at follow-up to be receiving the highest grant for which they were eligible. Further, successfully connecting families to social assistance grants appears to be an important contributor to household food security and obtainment of basic and educational material resources.

These findings are highly relevant to the public sector response; DSD has committed to the national scale-up the National Association of Child Care Workers' Isibindi home visiting model, one of the paraprofessional programs included in this study (AIDSTAR-Two, 2013). Further, the current 'National Strategic Plan for HIV, STIs and TB' includes specific emphasis on increasing the number of OVC households accessing grants as a key output for 2012–2016 (South African National AIDS Council, 2012). Our results suggest that if the scaled-up program can provide services on par with its performance at the sites included in this study, significant increases in grant access are possible. Findings further corroborate the effectiveness of linking HIV-affected families to this critical resource as a means to improve their wellbeing on several fronts.

Families affected by HIV and/or those that foster orphans experience elevated economic burdens and face competing demands on often already minimal resources. For instance, adults who fall ill may be unable to work and contribute to household income, and even free or subsidized HIV treatment requires regular medical appointments, representing substantial time and transport costs. Further, in highly affected communities families become larger as surviving adults take in orphaned children and the ratio of dependents to earners increases. This longitudinal study illustrates that in spite of the serious financial challenges facing HIV-affected families, cash transfer funds continue to be used to address children's basic needs, a finding that is consistent with cross-sectional population-based research from South Africa (DSD et al., 2012).

Maximizing the reach and benefits of cash transfer programs is a salient need across sub-Saharan Africa. Many programs are still limited in scale, and questions abound about the feasibility of national implementation (Richter, 2010). Community driven recruitment strategies have been pivotal to many of these programs, some explicitly directed to HIV-affected households—who may be among the country's most marginalized households. In randomized controlled trials, external volunteers have been used to help families achieve compliance with the

terms of conditional cash transfer programs (Robertson et al., 2013). Our findings suggest that once cash transfer programs go to scale a reliance on volunteer-driven services is inadequate. Instead, a paraprofessional workforce that is well trained, regularly monitored and adequately compensated is needed to reliably facilitate grant access among needy families. This finding aligns with wider calls for a professionalized service base for OVC support (Nyberg et al., 2012).

Importantly, however, while this study illustrates that trained and compensated home visitors have substantial potential to facilitate families' access to social grants, there is room for improvement. Even among households served by programs staffed by paraprofessionals about one-fifth were not receiving a grant, and an equal amount were eligible for a grant with a higher monetary value than the one they were receiving. Programs should consider additional strategies such as formalizing annual eligibility assessments for beneficiaries, offering continuing education for home visitors to keep them abreast of changes in the grant system, creating clear linkages with grant administrators at the South African Social Security Agency to facilitate the application process, and training home visitors to follow-up on applications that are pending approval. Building home visitors' capacity for effective needs assessment and service delivery coupled with enhanced collaboration between government and civil society is needed to help ensure 100% coverage for vulnerable families.

While these findings illustrate the potential promise of investments in high quality home visiting and social cash transfer programs and add to the body of evidence for effective community-based service delivery for OVC, the study is not without limitations. The nature of the intended roll-out of community-based home visiting among the participating program partners coupled with the national availability of social grants precluded randomization at the community or household level. Further, the study lacks a fully unexposed control group, another consistent challenge in community-based operations research. Fortunately, the potential for bias is reduced substantially through the use of longitudinal data and multivariate models that control for differences in observable characteristics across sites and study participants.

It should also be noted that while this study focused on the two most common child-focused grant types in South Africa, the potential contribution of social assistance grants for other members of the household to food security and children's resources were not considered. This is important because application assistance may increase access to numerous grants simultaneously; the impact of these individual child-level grants may thus be confounded. Moreover, the study did not collect information on the exact timing of grant uptake. While the maximum possible period between grant uptake and outcome measurement was two years, it was likely shorter in some cases. While important effects were evident, the full benefits of grant procurement may not have emerged measurably within this short period.

## 6. Conclusion

The HIV epidemic exacerbates economic hardship: medical costs, lost income, and expenses associated with fostering additional children can all compound families' impoverishment. Cash grants are an

**Table 4**

Impact of grant uptake on children's outcomes, among children eligible for a new grant.

Outcome predicted	Sample prevalence (%)		Impact of new grant uptake OR (SE)
	Baseline	Follow-up	
Model 1: Basic material resources	52	67	2.37 (0.44)***
Model 2: School resources	60	70	2.14 (0.41)***
Model 3: Food security	15	25	1.48 (0.33)†

† $p < 0.10$ ; \*\*\* $p < 0.001$ .

All models control for child characteristics, caregiver characteristics and household characteristics listed in previous table footnote. In addition, model 2 controls for reported assistance with school supplies by the program and model 3 controls for reported food parcel provision by the program during the study period.

important tool to alleviate poverty, and are an integral part of South Africa's social protection scheme. However, successful strategies for promoting grant access among prospective beneficiaries will be critical to realizing the impact of these programs. Results from this study suggest that, with sufficient training and support for care workers, home visiting can link highly vulnerable children and families to this critical resource. Future studies may help identify other attributes of home visiting—such as home visitors' needs assessment practices or knowledge about grant eligibility and application requirements—that can most effectively bridge gaps in grant access.

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